

MANAGED CARE OPTIONS FOR MEDICAID LONG-TERM SERVICES AND SUPPORTS





An Unsustainable Course

Medicaid costs continue to climb nationwide, taking up an increasing percentage of state budgets. These expenditures are forecasted to increase from \$436.6B in 2013 to \$738.8B by 2020.¹ Long-Term Services and Supports (LTSS) costs represent almost one-third of all Medicaid spending, and service delivery is often disconnected and financially misaligned. Compelled to action by tighter budgets, state leaders are increasingly looking to managed care (MC) systems in order to control costs. As stated in the Center for Health Care Strategies' report *Profiles of State Innovation*, "Overhauling the delivery of long-term care offers significant opportunities for states to improve health care quality, control costs, and enhance the quality of life for millions of Americans."

Seventeen states have implemented managed care arrangements for LTSS, and more are expected to move in this direction once coverage expansion under the Affordable Care Act (ACA) allows millions of newly eligible Americans to enroll in Medicaid.²

Alvarez & Marsal (A&M) has prepared this primer to serve as a guide to help inform states' decision making processes supporting transformation into a managed LTSS system. The following sections discuss three managed care models, their respective structures, the advantages and challenges of each, as well as additional considerations for states including enrollment, financial management and procurement.

¹Centers for Medicare & Medicaid Services. (2013). National health expenditure projections 2012-2022. Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf>

²"The Medicaid Program in 2014 and Beyond: The View from CMS", Cindy Mann. Medicare Medicaid Dual Eligibles Conference, September 2013.

Forms of Managed Care

While managed care is often considered as a single, homogenous solution to curb Medicaid costs, in reality there are many forms the program can take. States considering implementing a MC program for LTSS have to make important decisions around organizational structure, risk allocation, participant population coverage, quality control measures, services covered, and payment methods. Moreover, private managed care organizations (MCOs) often only have experience servicing populations with physical and behavioral health disabilities. New contract negotiations must maximize a different service model that caters to enrollees with intellectual and developmental disabilities and establishes enforceable performance standards to that end. Fortunately, as described above, the fact that many states have already implemented Medicaid Managed Long Term Services and Supports (MLTSS) programs, provides instructive examples to current state leaders.

This paper explores the options available to government agencies by examining three different models of managed care and providing examples of each:

- ◆ Risk-Based Managed Care
- ◆ Integrated Managed Care
- ◆ Prepaid Inpatient Health Plans

While each state that has moved to managed care chooses a unique program, every state's managed care model contains elements of the three typical models identified above. For each model, the corresponding section will describe the general structure, identify advantages and challenges, and provide case studies from states.

CARE MODEL	UTILIZES CAPITATED RATES	PROVIDES COMPREHENSIVE CARE	FINANCIAL RISK BEARER*
Traditional / Fee-for-Service		✓	State Health Departments
Risk-Based	✓	✓	Insurance Company
Integrated	✓	✓	Provider Network
PIHP	✓		PIHP Entity

* Defined as the risk of increased costs per person due to changes in support needs

Risk-Based Managed Care

OVERVIEW

Increasingly, state governments have been using risk-based managed care systems with capitated rates to deliver care to patients with intellectual and developmental disabilities. Some states such as Arizona have had these systems in place since the late 1980s in an attempt to control spending while continuing to deliver a high level of care.³ Others have turned to this version of managed care recently in the face of budget shortfalls and the impending expansion of Medicaid roles in 2014 under the ACA. As costs continue to grow for this patient segment, states look to this form of managed care to mitigate their potential risk.

STRUCTURE

In principle, risk-based systems work similarly to standard physical health managed care programs. Health insurers assume the risk for covered benefits by agreeing to actuarially sound capitated rates for services. These health insurers partner with and manage facilities, nursing homes, and specific physicians to ensure the quality and timely delivery of services. They are motivated by potential profits to drive service delivery efficiencies. Insurers make a profit if they are able to realize efficiencies and adequately deliver patient care below capitated rates. In this model, the challenge to the state then is ensuring that the quality of service levels and outcomes are maintained.

RISK-BASED SNAPSHOT #1: THE ARIZONA LONG TERM CARE PROGRAM

Managed Care Type: Risk-Based

Initial Year: 1988

Waiver Authority: 1115

Eligible Populations: Children, Adults under 65 with physical disabilities, Adults under 65 with intellectual and developmental disabilities (ID / DD), and Adults over 65.

Enrollment: 52,251

Payment Structure: The Arizona Department of Health Services has agreements with pre-negotiated rates with a system of private contractors. Currently, four different contractors are delivering care within a mandatory program to patients requiring LTSS needs. Contractors are responsible for a needs assessment as well as the delivery of services. All services are subject to monthly capitated rates including Home and Community-Based Services (HCBS).

RISK-BASED SNAPSHOT #2: WISCONSIN'S FAMILY CARE LONG-TERM CARE PROGRAM

Managed Care Type: Risk-Based

Initial Year: 1999

Waiver Authority: 1915(b) and 1915(c)

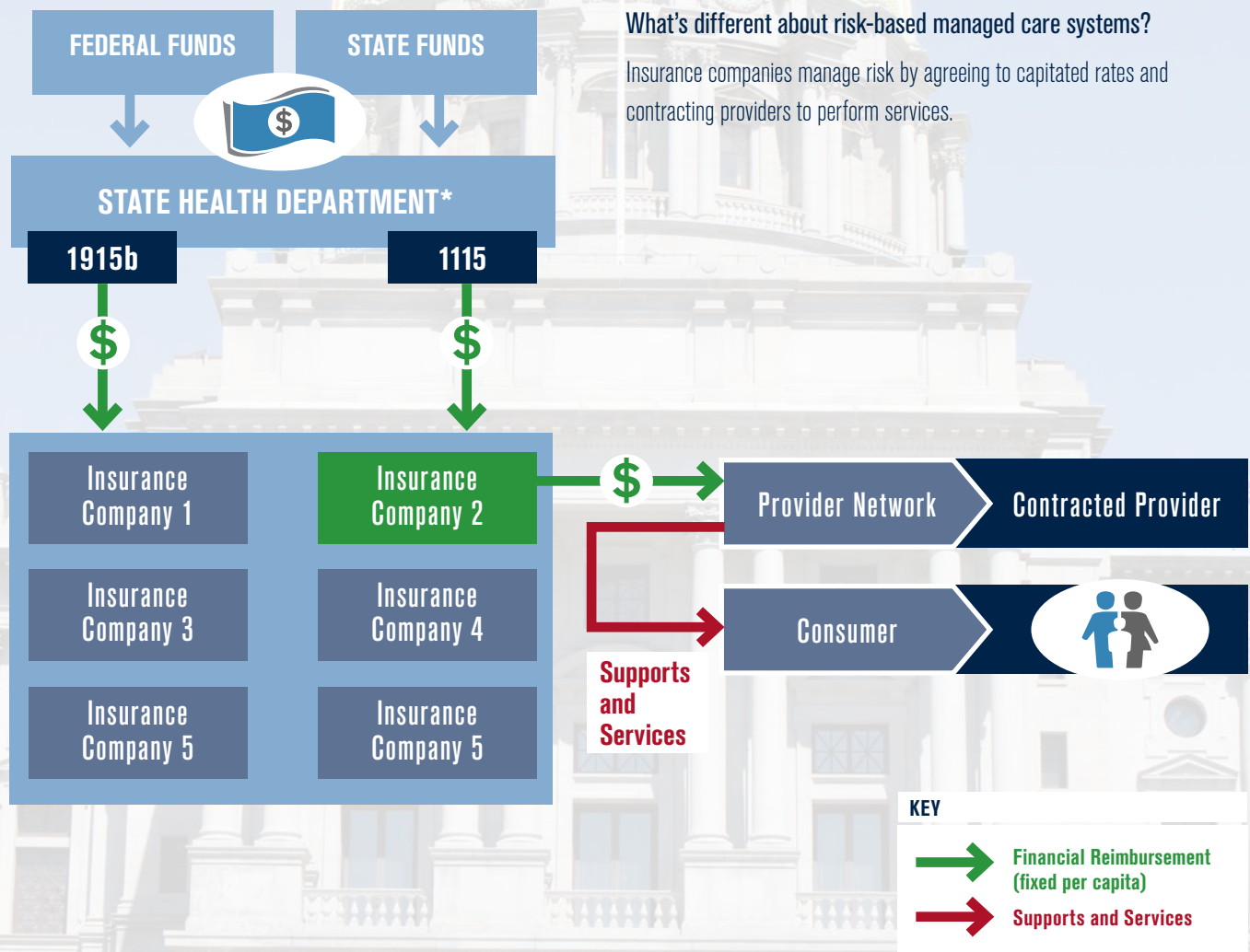
Eligible Populations: Adults under 65 with physical disabilities, Adults under 65 with ID / DD, and Adults over 65.

Enrollment: 33,141

Payment Structure: The state government entity agrees to pre-negotiated rates with a system of nine non-profit county-based contractors. Enrollment in the program is voluntary, with Aging and Disability Resource Centers determining initial eligibility and Managed Care Organizations (MCOs) updating care needs upon enrollment. Capitated rates are paid to contractors for services including HCBS, personal care, intermediate care facilities for individuals with mental retardation (ICF / MR), and mental health needs.

³Lind, A., Gore, S. & Somers, S. (2010, November). Profiles of state innovation: Roadmap for managing long-term supports and services. Center for Health Care Strategies, Inc., Retrieved from http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf

The following figure illustrates the flow of funds and services in a sample risk-based managed care system



* 1915b, 1915c and 1115 Medicaid waivers for managed care, home and community-based services, and state research and demonstration

USING RISK-BASED MANAGED CARE PRESENTS ITS OWN UNIQUE SET OF ADVANTAGES AND CHALLENGES WHEN DEALING WITH POPULATIONS REQUIRING LTSS:

ADVANTAGES

- 1) **Complete Risk Mitigation** – Fiscal risk is transferred from the state Medicaid entity to the MCO by setting per patient capitated rates.
- 2) **More Predictable Budgeting** – With less risk, state health departments have more predictable spending each year and are able to focus on tracking service quality.
- 3) **Ability to Capture Synergies** – Combining a new managed care program with an existing Medicaid program creates data-sharing opportunities that lower both service and administration costs.
- 4) **Ability to Leverage the Knowledge and Resources of MCOs** – Risk-based managed care systems put the decision-making in the hands of large corporations with resources and experience in both rate-setting and facilitating community-based care in an efficient manner.⁴ These private companies are incentivized to experiment with new methods of care delivery and to invest in new technologies that improve the system.

CHALLENGES

- 1) **Diverse Profile of Enrollees** – There is no single profile of LTSS participants. Participants in need range from children to the elderly and span all levels of acuity. With the highest per capita spending of all Medicaid enrollees and a large range of complex needs, setting accurate and properly balanced capitated rates for this population is a technical, contractual, and political challenge. An additional challenge with LTSS participants is that they can remain in the Medicaid system for decades — making risk assessment for MCOs very challenging.
- 2) **Providing Care for High Cost Cases** – High-acuity cases put pressure on managed care organizations to petition for relief from established rates through the exception processes. These cases also may incentivize providers to opt out of the system if they feel compensation is inadequate.
- 3) **Significant Oversight Responsibilities** – Careful contracting and state oversight is essential to managing stakeholders and maintaining a high quality of care for this sensitive population. “Secret shopper” audits and quality performance metric data are two great methods to ensure appropriate care.⁵
- 4) **Balancing Rates with Available Funding** – Actuarially sound rates must be balanced with budget constraints, and in practice, Medicaid payments depend on the availability of state funds.⁶

⁴ Galewitz, P. (2011, February 21). States turn to private insurance companies for managed care. USA Today. Retrieved from http://usatoday30.usatoday.com/money/industries/health/2011-02-21-longtermcare21_ST_N.htm

⁵ The Kaiser Commission on Medicaid and the Uninsured. (2012, September). Current and emerging issues in medicaid risk-based care: insights from an expert roundtable. Retrieved from <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8364.pdf>

⁶ Catterall, G., Chimento, L., Sethi, R., & Maughan, B. (2006). Rate setting and actuarial soundness in medicaid managed care. The Lewin Group, Retrieved from http://mhpa.org/pdf/misc/ACAP_MHPOAreport.pdf



Integrated Managed Care

OVERVIEW

A developing option for a MC structure used in North Carolina and piloted in Pennsylvania involves eliminating the insurance company from the administration of managed care functions (i.e. insurance company / insurance plan) and redirecting that role to the provider networks. Providers would then be responsible for health plan management along with the delivery of services. Capitated payments would be made directly to these service networks as they actively manage the risk of both high and low acuity patients. This model could potentially lower overall costs to governments by eliminating system complexity and administration fees. Also, only one organization is responsible for enrolled member services, which allows for better transparency and accountability of providers. Finally, provider profit is capped at a negotiated and reasonable percentage (e.g. three percent) to support long-term sustainability, *and savings may be reinvested into expanding enrollment to serve more people.*⁷

INTEGRATED SNAPSHOT #1: PENNSYLVANIA ADULT COMMUNITY AUTISM PROGRAM (ACAP)

Managed Care Type: Integrated MC

Initial Year: 2009

Waiver Authority: 1915(a)

Eligible Populations: Individuals diagnosed with autism spectrum disorders that require physical, behavioral and community services.

Enrollment: 140

Payment Structure: Contractor receives a standard payment per member per month to provide physical health and community based services. The Contractor is responsible for developing the plan of care and managing within the capitated payment. The program is small, voluntary and provider choice is currently limited to one.

⁷ Council, M. D. (n.d.). After We're Gone: Part 2: Where Can We Find Support ., (pp. 1-36).

STRUCTURE

Integrated Managed Care promises a simpler and more efficient structure to deliver services by keeping familiar aspects of common managed care systems but eliminating the MCO “middle man.” It may operate within a normal waiver and include applicable health plans and Accountable Care Organizations. Services are fully capitated and funded on a per-member per-month basis to ensure that personalized options can be greatly expanded. Members have a choice to contract with competing state-wide service networks to ensure quality. Independent third party organizations will ensure provider compliance within service networks and conduct regular rate and quality audits.

INTEGRATED SNAPSHOT #2: NORTH CAROLINA MH / DD / SA HEALTH PLAN WAIVER

Managed Care Type: Integrated MC

Initial Year: 2005, statewide expansion began in 2013

Waiver Authority: 1915(b) & 1915(c)

Eligible Populations: Children and Adults of all ages with developmental disabilities (DD), intellectual disabilities (ID), substance abuse disorders, mental illness, and /or emotional disturbances.

Enrollment: 4,699

Payment Structure: Nine contractors, called Local Management Entities (LMEs), receive a capitated payment per member per month to provide behavioral health and /or community based services and supports. The LMEs are responsible for developing the plan of care and managing within the capitated payment. Enrollment is mandatory for all qualified Medicaid participants.

In 2011, the North Carolina MH / DD/ SA Health plan waiver was chartered via legislation with the goal of establishing a system capable of managing public resources available for mental health, intellectual and other developmental disabilities and substance abuse services, including federal block grant funds, federal funding for Medicaid, and all other public funding sources.⁸ The MH / DD / SA services for Medicaid recipients and the uninsured are managed by nine Local Management Entities (LMEs) that will function as MCOs based upon a pilot model that originally covered five counties. The decision to use LMEs to act as the MCOs is an example of integrating between the provider networks and local government. The LMEs are county-level government public agencies that bear the risk for providing comprehensive care to the targeted populations and managing qualified provider communities, rather than their traditionally narrow role of supervising the enrollment intake process and providing case management services.⁹ Implementation was staged in tiers beginning in October 2011 and ending with LME-MCOs planning to begin operation in January 2013. State law required the transition of the entire state to the 1915 (b) / (c) Medicaid Waiver by July 1, 2013.

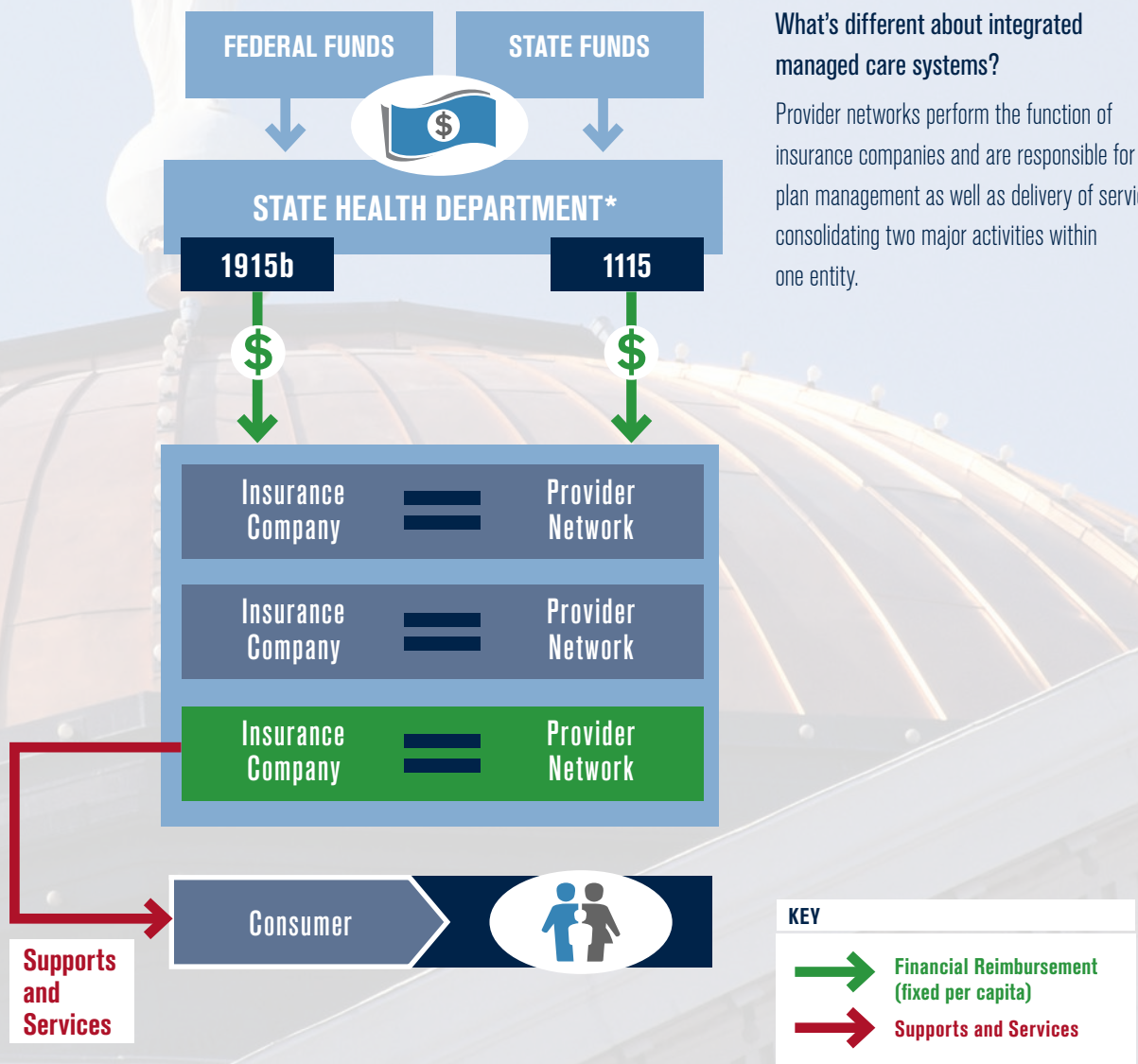
Preliminary results of the arrangement have been mixed. Capitated rates have decreased by over ten percent, but there have been concerns from stakeholders about a lack of access to specialty care. In a recent proposal for reform, DHHS is contemplating the consolidation of the LME-MCOs into four entities and incorporating more outcome-based measures into the contract structure to drive care improvements.¹⁰

⁸ What is the 1915 (b)/(c) Medicaid Waiver? (2012). Retrieved from <http://www.ncdhhs.gov/mhddsas/communicationbulletins/2012/commbulletin123/1915bc-factsheet.pdf>

⁹ Medicaid Waiver Contract. Retrieved from <http://www.ncdhhs.gov/mhddsas/statpublications/Contracts/DHHS-LMESFY11Contract.pdf>

¹⁰ Proposal to Reform North Carolina's Medicaid Program. (2014, March 17). Retrieved from http://ncdhhs.gov/pressrel/2014/DHHS_Medicaid_Reform_Legislative_Report-2014-03-17.pdf

The following figure illustrates the flow of funds and services in a sample integrated managed care system



What's different about integrated managed care systems?

Provider networks perform the function of insurance companies and are responsible for plan management as well as delivery of services, consolidating two major activities within one entity.

* 1915b, 1915c and 1115 Medicaid waivers for managed care, home and community-based services, and state research and demonstration

USING INTEGRATED MANAGED CARE PRESENTS ITS OWN UNIQUE SET OF ADVANTAGES AND CHALLENGES WHEN DEALING WITH POPULATIONS REQUIRING LTSS:

ADVANTAGES

- 1) **Opportunity for Reinvestment** – This structure includes a pre-defined profit cap for providers which allows for greater reinvestment into the system. For example, providers can use profits to decrease waiting lists for services.
- 2) **Decreased Complexity** – Removing contracted insurance plans with for-profit companies may decrease regulatory and reimbursement complexity and simplify government negotiation processes.
- 3) **Increased Opportunity for Oversight** – Government entities are able to focus on setting policy, allocating resources, and carrying out oversight rather than concentrating on rate-setting and reimbursement.

CHALLENGES

- 1) **Organizational Role Changes** – Transferring to this model will likely alter the current roles of state government staff members and will require operational changes and create short-term inefficiencies.
- 2) **Start-Up Costs** – There will likely be start-up costs to establish the infrastructure and risk reserves necessary to ensure the program runs smoothly.
- 3) **High-Acuity Cases** – High-cost cases can become a point of contention as providers may not have the necessary financial incentives to serve the high-acuity population.
- 4) **Incongruent Skill Set** – In general, service providers do not have the track record of showing they can coordinate care and achieve cost savings.

Prepaid Inpatient Health Plan (PIHP)

OVERVIEW

Another managed care option that state government health departments utilize is to contract with Prepaid Inpatient Health Plan (PIHP) providers to administer community health services. Usually, these PIHPs are responsible only for the delivery of inpatient hospital or institutional services, such as inpatient behavioral health care, and do not have a comprehensive risk contract. In some cases, they may be paired with complementary providers to offer a full suite of services to participants. Michigan provides such an example where the PIHPs are paid on a capitated basis and assume the risks of providing all supports for its enrollees in both a 1915 (b) and a 1915 (c) waiver named by the Habilitation Supports Waiver (HSW). The PIHP is responsible for administering the HSW locally, providing all services through its network.¹¹

STRUCTURE

Under federal regulation, PIHPs are the legal organizations that Departments of Community Health (DCH) contract with to administer capitated community health services in the states. The Centers for Medicaid & Medicare Services (CMS) typically specifies a capped number of enrollment slots per fiscal year to PIHP programs. These programs then manage and allocate the enrollment slots to local health services programs. PIHPs are similar to MCOs in the sense that they may contract with providers and work with capitated monthly funding, but they are not required to provide a full scope of medical services to patients. Rather, PIHPs administer “carve out” programs according to state contracts that outline specific inpatient services.¹² For example, a state agency may enroll a new patient into a PIHP program to provide that person with a regimen of inpatient speech and physical therapy care.

PREPAID INPATIENT SNAPSHOT: THE MICHIGAN SPECIALTY SERVICES AND SUPPORT PROGRAM

Managed Care Type: PIHP

Initial Year: 1998, ID / DD services added in 2002

Waiver Authority: 1915(b) and 1915(c) operating concurrently

Eligible Populations: Individuals with developmental disabilities (DD), intellectual disabilities (ID), substance abuse disorders, mental illness and / or emotional disturbances.

Enrollment: 41,000

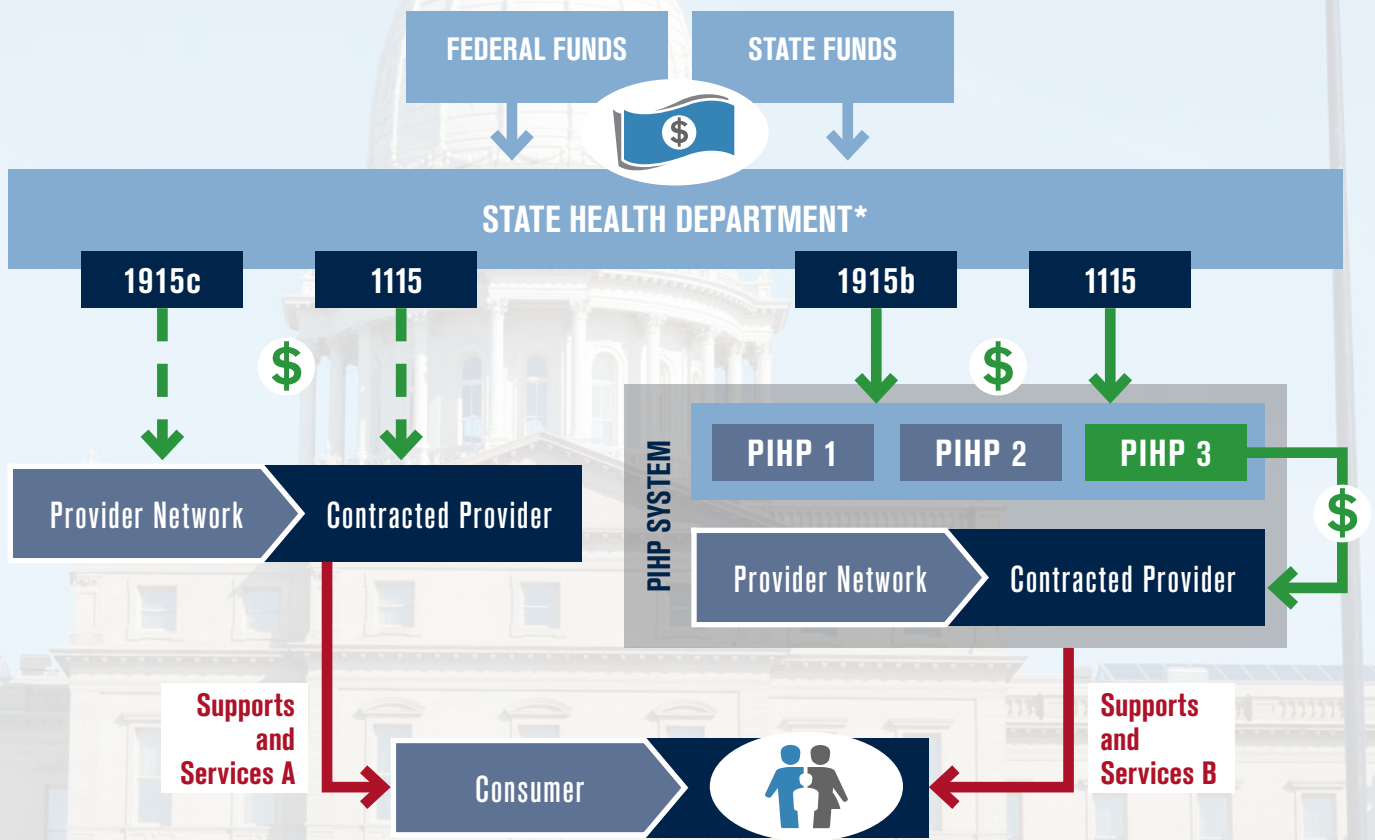
Payment Structure: Each PIHP receives blended capitated per member per month payments from the Department of Community Health, which vary slightly depending on each Medicaid eligibility group. Reimbursement is broken down into two payments: one payment covers services under the 1915 (b) waiver and the other pays for the services offered under the Habilitation Supports Waiver (HSW) program.

¹¹ Services, C. f. (2013, March 26). Michigan.gov. Retrieved from Michigan Documents:

http://www.michigan.gov/documents/mdch/Managed_Specialty_Services_and_Supports_Waiver_364598_7.pdf

¹² vLex. (2013). Code of federal regulations - title 42: Public health (2010). Retrieved from <http://cfr.vlex.com/vid/438-2-definitions-19809692>

The following figure illustrates the flow of funds and services in a PIHP system



What's different about PIHP systems?

PIHP systems typically operate within normal health care delivery systems and are each responsible for the delivery of specific services. A consumer will use a PIHP network to supplement their regular comprehensive plan with additional care.

KEY

- Financial Reimbursement (fixed per capita)
- Financial Reimbursement (variable per capita)
- Supports and Services

* 1915b, 1915c and 1115 Medicaid waivers for managed care, home and community-based services, and state research and demonstration



USING A PIHP SYSTEM PRESENTS ITS OWN UNIQUE SET OF ADVANTAGES AND CHALLENGES WHEN DEALING WITH POPULATIONS REQUIRING LTSS:

ADVANTAGES

- 1) **Improved Coordination of Care** – Compared to a fee-for-service structure, PIHP systems better ensure that those requiring LTSS services receive care coordinators, which means improved access to preventative care and less duplication of services.
- 2) **Allows Phased Adoption of Managed Care** – PIHPs allow agencies to move portions of their care delivery system to a capitated program, which may provide more plan familiarity and depth of provider services, while delaying more complicated or less suitable populations / services to a later date.
- 3) **Ability to Leverage a Mature Program Infrastructure** – In most states, the infrastructure for a PIHP system has already been developed with a critical mass of providers ready to deliver services. The plans simply restructure the existing operating arrangement among providers. States can begin to capture savings immediately without worrying about whether all needs will be covered.

CHALLENGES

- 1) **PIHPs Are Not Comprehensive** – PIHPs alone do not cover the entire range of services needed to serve most LTSS patients and typically focus on a limited number of offerings. The plans must be supplemented by another service model, adding complexity and requiring increased coordination.
- 2) **Difficulty Ensuring a Standard Array of Services** – As a result of the decentralized structure, standardizing policies across all local health services programs to ensure equal access to services can be a challenge. If policies are not sufficiently detailed, local entities may develop their own interpretations that result in inconsistencies across the state.
- 3) **Difficulty Meeting Specialized Needs** – States may be challenged to help the plans build out a specialized network of providers for specific mental health service areas such as services for the deaf or blind.

RISK-BASED MANAGED CARE

INTEGRATED MANAGED CARE

PREPAID INPATIENT HEALTH PLANS

BELOW IS A CHART SUMMARIZING THE ADVANTAGES AND CHALLENGES OF EACH OF THE AFOREMENTIONED MANAGED CARE OPTIONS:

RISK-BASED MANAGED CARE	INTEGRATED MANAGED CARE	PREPAID INPATIENT HEALTH PLANS
Advantages		
<ul style="list-style-type: none"> Complete Risk Mitigation More Predictable Budgeting Ability to Capture Synergies Ability to Leverage Knowledge and Resources of MCOs 	<ul style="list-style-type: none"> Opportunity for Reinvestment Decreased Complexity Increased Opportunity for Oversight 	<ul style="list-style-type: none"> Improved Coordination of Care Allows Phased Adoption of Managed Care Ability to Leverage a Mature Program Infrastructure
Challenges		
<ul style="list-style-type: none"> Diverse Profile of Enrollees Providing Care for High Cost Cases Significant Oversight Responsibilities Balancing Rates with Available Funding 	<ul style="list-style-type: none"> Organizational Role Changes Start-Up Costs High-Activity Cases Incongruent Skill Set 	<ul style="list-style-type: none"> PIHPs Are Not Comprehensive Ensuring a Standard Array of Services Can Be Difficult Specialized Needs Are Difficult to Meet

Considerations for States

ADDITIONAL KEY CONSIDERATIONS FOR STATES EXPLORING THE DEVELOPMENT OF A MANAGED CARE PROGRAM ARE CATALOGED IN THE TABLE BELOW:

CATEGORY	ISSUE	CONSIDERATIONS
Enrollment	<i>Voluntary vs. Mandatory Enrollment</i>	<ul style="list-style-type: none">▪ Mandatory programs guarantee a higher enrollment, allowing the critical mass required for a viable and robust provider network.▪ Dual eligible (those opting for both Medicaid and Medicare services) enrollment must always be voluntary.▪ Voluntary enrollment preserves freedom of choice.
	<i>Managing the Enrollment Function</i>	<ul style="list-style-type: none">▪ Contracting with a third party enrollment broker removes the operational risk from the state.▪ Using the entity that conducts eligibility (e.g., county or regional office) to conduct enrollment allows for more control and integration between processes.▪ Careful consideration must be made with providers regarding payment and coverage regarding high-cost conditions such as mental disorders and acute medical needs.
Financial Management	<i>Capitation of Targeted Benefits</i>	<ul style="list-style-type: none">▪ Including some, but not all of the MLTSS program's covered services in a monthly capitated payment is advisable if the state chooses a limited contractor that does not possess the required experience or financial capacity to be at risk for all services.▪ In this case, it is important to make the contractor responsible for coordinating all services to ensure continuity of care.
	<i>Risk Adjustment</i>	<ul style="list-style-type: none">▪ Risk adjustment refers to a range of strategies that states may use to make capitated payments more predictive of member costs.▪ Risk adjustment provides an incentive to serve higher cost individuals by increasing the payment for those persons.▪ Risk adjustment is an underdeveloped process which may result in incorrect adjustments.
	<i>Performance Incentives</i>	<ul style="list-style-type: none">▪ Special incentives can be used to address specific issues such as high direct care staff turnover and insufficient access to choice of care in rural areas.

CATEGORY	ISSUE	CONSIDERATIONS
Procurement and Evaluation	<i>Purchasing Strategy</i>	<ul style="list-style-type: none"> Agencies must decide how to test the market for MCOs, e.g. whether to issue a Request for Qualifications (RFQ) followed by a Request for Proposal (RFP) or use another method. A popular option is to initiate a small pilot program to prove the concept. Agencies must ensure that the bidding documents include provisions for providers to regularly report on performance, including quality and speed of services delivered. Careful pre-planning is required to negotiate contract terms with MCOs that establish the correct balance of fiscal incentives and consumer protections. Since most private MCOs only have experience in providing services to enrollees with physical and behavioral health disabilities, states must be prepared to discuss terms that better serve ID/DD populations to ensure an appropriate service model and performance standards. States must ensure that the contract allows flexibility for the care providers to incorporate innovative practices in service delivery.
	<i>Determining Contractor Qualifications and Experience</i>	<ul style="list-style-type: none"> The number of providers and the size of the contractors should be determined according to specific state needs. Agencies must develop a rigorous rating system to rank contractors based on important qualifications such as years of experience in the industry, financial resources, proposed approach, etc. States should consider including special criteria that rewards the use of existing providers and organizations in state to improve relationships with important stakeholders.
	<i>Evaluation and MCO Management</i>	<ul style="list-style-type: none"> Regular meetings with providers can center around service improvements and progress. If fee for service (FFS) components are used, consider setting utilization targets. States may introduce training goals to address major areas of concern or specific target populations. Training can ensure uniformity in knowledge across providers throughout the network.

Table Source: Centers for Medicare and Medicaid Services, (2013). Managed care long-term services and supports. Retrieved from website: <http://www.medicaid.gov/mltss/design/design.html>



Looking Forward

Managed care may not be the appropriate model for every state's Medicaid LTSS population. However, for those states which opt for managed care, designing and implementing a managed care program is a challenging and time-intensive process. A state's success will depend on a variety of factors — both those discussed in this paper and others including continuity of leadership, relationship capital with the stakeholder community, and existing program and technical infrastructure. The information in this paper can serve as a primer for leaders considering viable alternatives to the FFS model.

Alvarez & Marsal

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- Risk assessment
- Operational design and care delivery planning
- Program design and oversight
- Stakeholder management and communications

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